**For Washington State Nursing Home staff**

**From Residential Care Services, Aging and Disability Services**
**Department of Social & Health Services**

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**January 2009**

***our mascot***
**Cousin IT**

# *"This is I.T." Newsletter*

Info and Tips from the MDS-WA Office—***Clinical*** *stuff,* ***Computer*** *stuff,* ***Reports*** *'n stuff, and other STUFF!*

*By Marge Ray and Shirley Stirling, State of WA, DSHS*

## Is it really just the blahs?

**Coding MDS Section E with Special Focus on E1**

As the seasons change and days get shorter, some people experience feelings of hopelessness and sadness, a drop in energy levels with decreased physical activity, fatigue, irritability, difficulty concentrating, appetite changes, and sleeping for longer periods of time. This condition is often called seasonal affective disorder (SAD) or "winter depression." In many elders, this condition is not confined to the winter months, but is present all year long.

For residents in nursing homes, depression and other mood disorders such as sadness and anxiety are common, but often under diagnosed and undertreated. When left untreated, mood disorders are disabling and associated with increased risk of death, functional decline, and unnecessary suffering by the individual, family and others in the person's life.

**Section E** of the MDS, helps facilities identify mood and behavior symptoms that may indicate a depression or the presence of anxiety in nursing home residents that can be treated. Unfortunately, these items are often miscoded.

**What are some of the factors that make coding Section E so difficult?**

**Time Frame**

Partially it is the different time frames for each item:

- E1-Indicators of depression, anxiety, sad mood is a **30-day** assessment window
- E2-Mood persistence is a **7-day** assessment window but is based on information collected in E1, which has a 30-day window. You must be able to identify moods that occurred in the last 7 days of that 30 day period in order to code this item
- E3-Change in mood is a **90-day** assessment window.
- E4-Behavioral symptoms is a **7-day** assessment window.
- E5-Change in behavioral symptoms is a **90-day** assessment window.

**Day Shift Only**

The persons most often assigned to complete this section (Social Services staff) may only see residents on day-shift during the week days. Moods and behaviors happen 24/7.

**Perceived Implications**

There may be hesitation to code mood/behavior indicators due to perceived negative implications (e.g., high QI/QM numbers or labeling a resident as "depressed".

**Making Assumptions**

Staff may think that the indicator is caused by a physical problem, rather than a mood or behavioral issue, so it does not get coded.

**Direct Care Staff**

Direct care staff (most often nursing assistants) may not report what they experience because what they see or hear is how the resident "usually behaves" or the resident "did not mean to do or say it".

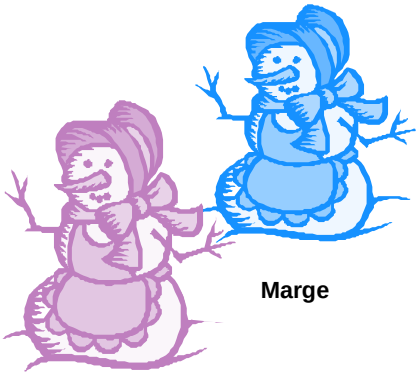
**Auxiliary Staff**

Auxiliary staff such as housekeepers, maintenance, business office, dietary, etc., may not know, unless you have an education program in place, about the assessment processes in the facility. They may not know that their observations are important and need to be shared. They may also may not know who to tell when they have observations to report.

***Inside this issue:***



## *"I.T." wishes you a Happy New Year!*



**Marge**

**Shirley**

## Our goal...

Our goal is to help you accurately assess, code, and transmit the MDS.

Accurate assessment forms a solid foundation for individualized care to help residents achieve their highest level of well-being.

# Connecting the MDS dots… E1 Coding Scenario

**Test yourself with this scenario:**

**Mrs. Winters was admitted to your nursing home 4 weeks ago. Initially, she was upset and angry about being in the nursing home and stayed in her room. She declined invitations to attend any activities that first week including her very favorite, Bingo. That first week she had many health complaints, was not sleeping well at night (this was unusual for her) and stated several times that she thought she would just "have a heart attack and die".**

**In the last 2 weeks, Mrs. Winters has had no health complaints of any kind, is sleeping well all night, and attends all activities offered. She states "everything is just fine, I like it here."**

***Your job is to code E1 using the scenario information.***

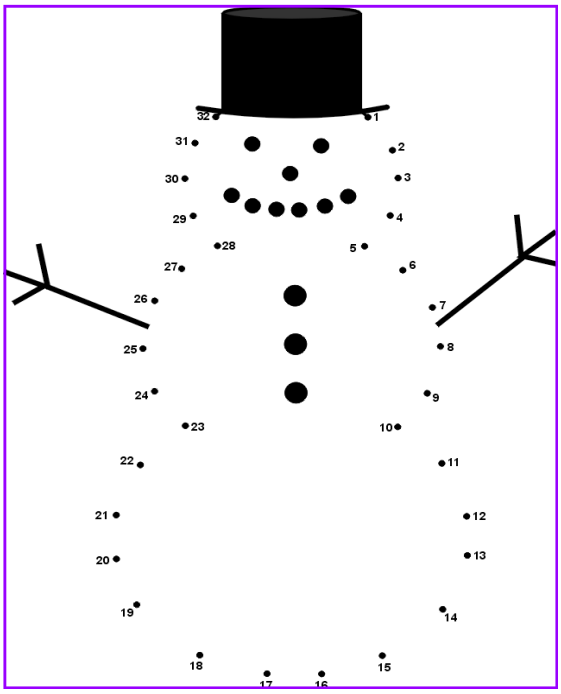
- Which E1 items would you code?
- Which of the following codes would be assigned to each item?

  a. "0" Indicator not exhibited in the last 30 days; OR

  b. "1" Indicator of this type exhibited up to 5 days a week (i.e., exhibited at least once during the last 30 days but less than 6 days a week); OR

  c. "2" Indicator of this type exhibited daily or almost daily (6,7 days a week).

*Please see Page 4 for the answer key.*



## What is in the future for coding Moods?

Experts in Geriatrics have concluded that Section E items on MDS 2.0 were not adequate for depression screening.

Several of the reasons for this have been discussed in this newsletter. As a replacement, the draft MDS 3.0 is scheduled to use the **PHQ-9, Patient Health Questionnaire.**

The tool is a check list of 9 symptoms of depression that is to be completed as a resident interview. This is one of several scripted interview tools that will be part of the MDS 3.0 data gathering process.

Facilities may want to start practicing using these scripted interviews either with residents or amongst themselves. Becoming familiar with the new tools now will help staff become more comfortable with the new process. The draft MDS 3.0 form has enough directions on it for staff to get a good feel for how the interviews will be done.

For a copy of the form, go to the following site and click on "***MDS 3.0 Draft Assessment Form***": http://www.adsa.dshs.wa.gov/Professional/MDS/Clinical/

## Q2IT *Tips from the Treasure Trove*

### Questions to I.T. (Q2 IT) on Section E - Mood & Behavior Patterns

**Question:** If a resident is seen crying because of being in pain, should E1m — Crying/Tearfulness be coded on the MDS since the crying is not caused by depression?

**Answer:** Yes, you must code E1m based on the observation of crying that was made during the 30 day window. Unless the crying occurred daily or almost daily, the coding would be a "1".

The RAI manual in chapter 3 page 62 states (emphasis added):

*"...for each indicator, apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember, code the observation, regardless of what you believe the cause to be."*

In this scenario, the crying does not necessarily mean the resident is depressed, but pain issues can, in some cases, cause depression. When items in E1 are identified, further assessment with development of appropriate interventions can occur.

**Question:** If a resident is having pain and requests medication, should we code E1h-Repetitive Health Complaints?

**Answer:** No, not based simply on a request for pain medication. Further assessment and observation will be needed:

1. Is there evidence that medication has been given and there is no change in terms of the resident's requests?
2. Have staff explored other nursing measures to relieve pain? This could include discussion with the physician to change the type or dosage of the medication, or non-pharmacological interventions such as position changes, massage etc.
3. Does the resident exhibit non-verbal symptoms of pain such as grimacing, guarding, or verbalizations with movement? If, after all of these areas have been evaluated, the resident continues to complain of pain, it may be that they are, in fact, "persistently seeing medical attention" (RAI manual definition chapter 3 page 61) and E1h could be coded.

# *The Diversity of Section E*


**There are *6 Resident Assessment Protocols (RAPs)* that may be triggered:**

- **Mood State (E1a-E1p = 1 or 2; E2 = 1 or 2)**
- **Psychotropic Drug Use (E1n = 1 or 2; E3 = 2; E5 = 2)**
- **Psychosocial Well Being (E10 = 1 or 2)**
- **Delirium (E3 = 2; E5 = 2)**
- **Falls (E4aA = 1,2 or 3)**
- **Behavioral Symptoms (E4aA-E4eA = 1,2 or 3; E5 = 1)**

**Section E is used in the *RUG-III Classification system for payment:***

- **In the Clinically Complex group, 3 or more E1 items coded as a '1 or 2' result in a higher group being assigned to that assessment as the resident is considered to meet the 'depression' criteria (e.g., CC1 becomes CC2)**
- **In the Behavioral Problems group, if items E4aA-E4eA are coded a '2 or 3' and the ADL index score is 10 or less, the assessment is classified into this group.**

**Section E calculates certain *Quality Indicators/Quality Measures:***

- **#2.1-Residents who have become more depressed or anxious**
- **#2.2-Prevalence of behavior symptoms affecting others**
- **#2.3-Prevalence of symptoms of depression without antidepressant therapy**

## Five Star Quality Rating System

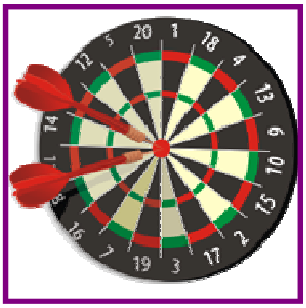
On December 18, 2008 the Centers for Medicare & Medicaid Services (CMS) unveiled the new "**Five Star Quality Rating System**" on the national Nursing Home Compare site: http://www.medicare.gov/NHCompare/. Nursing home Compare is a national web site provided to the public to help them evaluate nursing homes. With the new star system nursing homes:

1. Receive an **Overall Star Rating** that is based on facility performance on three types of measures: **Health Inspections, Staffing, and Quality Measures** and
2. Receive star ratings for each of these measures. Also there is a separate rating for RN staffing. CMS has published a 23-page **technical manual** that provides a description of the methodology and design for the Nursing Home Compare Five-Star Rating System. You may want to review this document to better understand how the star ratings were determined:

   http://www.cms.hhs.gov/CertificationandComplianc/Downloads/usersguide.pdf

# *How can I improve the accuracy of info recorded in the MDS?*

**The following points have broad application, but here we focus or 'target' on improving accuracy in the area of Mood and Behavior Patterns:**



- **Educate all nursing home staff** about moods and behaviors being assessed. Include the importance of reporting and/or documenting these issues when they occur, even if the indicators are chronic.
- If you are the person responsible for coding Section E, **do not rely solely on your direct observations or on your experiences with the resident.** Talk to staff across all shifts; review the medical record including nursing notes, therapy notes, physician progress notes, activity notes and social services documentation. Talk with not only the resident, but their family or friends, if possible.
- For residents newly admitted, remember to **gather information that happened prior to admission to your nursing home.** Use sources such as hospital records and interviews.
- **Document, document, document the presence of mood/behavior indicators** in the clinical record as this is a matter of good clinical practice. The form and format of this documentation is up to the facility, but it needs to be done.
- **Follow the coding directions in the RAI User's manual**, chapter 3 pages 60-70. Do not rely on coding instructions printed on the MDS 2.0 form as those instructions are abbreviated and do not provide the context or processes needed to assure accurate information.
- **Never code the MDS to manipulate payment or to avoid triggering Quality Indicators or Quality Measures.** If the moods/behaviors occurred, code them per the manual instructions, regardless of "why" they occurred.

**For Washington State Nursing Home Staff… A newsletter from Residential Care Services Of Aging & Disability**

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# MDS 3.0 Update

**Draft data submission specifications for MDS 3.0 were posted on the CMS website 10/22/08. These will be finalized in 2009.**

**A RAP workgroup has been appointed by CMS to update the current RAPS in terms of clinical relevance and to mesh with MDS 3.0 changes. Additionally, 2 new RAPS have been developed, including one for Pain. The entire package will be sent to CMS for approval early in 2009.**

**October 1, 2009 is still the target date for implementation.**

**Note: Be very cautious about attending MDS 3.0 coding seminars at this time. All materials are still draft and the instructional manual has not been finalized or released. The State RAI Coordinators will be trained during a conference in Baltimore in May, 2009. Washington State will provide training to all providers and RCS staff during the summer of 2009. Specific dates, times and locations are yet to be determined. You will be notified once final decisions are made.**

## State of WA NH web sites

**MDS Clinical web page**
http://www.adsa.dshs.wa.gov/Professional/MDS/Clinical/

**MDS Automation web page**
http://www.adsa.dshs.wa.gov/Professional/MDS/Automation/

**NH Rates web page**
http://www.adsa.dshs.wa.gov/professional/rates/

**Casemix web page**
http://www.adsa.dshs.wa.gov/professional/CaseMix/

**"Dear Administrator " web page**

**http://www.ADSA.dshs.wa.gov/professional/letters/nh/2008/**

**ADSA on the Web!**

**http://www.adsa.dshs.wa.gov/Professional/**

**Did you know…WA State RUG Reports** are no longer mailed, but instead available exclusively on the MDS Transmission site. Notices are sent out via the MDS-WA Listserv when the reports are posted. Other notices regarding MDS are sent usually up to about four times month. To join, send an email to LISTSERV@LISTSERV.WA.GOV and put this text in the subject line **SUBSCRIBE MDS-WA**

**Answers to E1 Coding Scenario**

*E1 items to be coded:*

E1d-Persistent Anger with self or others

E1g-Recurrent Statements that something terrible is about to happen.

E1h-Repetitive Health Complaints.

E1k-Insomnia/Change in Usual Sleep Pattern.

E1o-Withdrawal from Activities of Interest.

E1p-Reduced Social Interaction.

The coding choice for all of these items would be "b" the code of '1'-Indicator of this type was exhibited up to 5 days a week.

They could not be coded a "2" because the look back period for E1 is a 30 day window and in order to code daily or almost daily, the indicators would have had to occur more than 5 days a week over the entire 30 day period.

## Computer Corner— Login and Transmit

**LOGIN**—To increase data security, CMS will soon change the login ID and password you now use for CASPER reporting and MDS transmit.

Early in 2009 you will receive information about the new security system, which will allow two staff from each NH to request a Personal ID and password. The Personal ID/password will belong to the user exclusively. This means that the sharing of a Personal ID password will be considered a security violation. Once you a user registers for a new Personal ID and password, the old login will be retired.

**Action requested:** Please determine the appropriate two employees (who already have an MDCN H@ account) to select for a Personal ID and password. When it is ready, the Registration Link for assigning the new Personal ID and password will appear on the "Welcome to the CMS MDS System!" site.

**Note:** This will not affect your MDCN AT&T login ID and password. H@XXXX accounts will remain the same.

**TRANSMIT—**If you are now using broadband to transmit the MDS, congratulations and please continue doing so

However, if you are **not** using broadband to connect into MDCN, follow the new directions at http://www.qtso.com. Go to the *"Attention: Broadband..."* box and double-click.

Also, if you are **not** using broadband connection now, please call the MDCN Helpdesk at 800- 905-2069 for a new account id, user id and password. To help in the transition, a new account type has been created called ANRMS. This account id along with the AT&T Global Network user id (e.g. H@xxxx) will be used to create a new AT&T Global Network profile. With this, a user can connect with the new broadband solution or, if necessary, connect with dial-up. (Dial access will be terminated once a user has migrated to the broadband solution.)

In the future everyone will be able to reconfigure their connection with the new instructions. Right now we are focusing on those who most need the help.